

ARTICLE 4

SECTION 13

DENIAL/DISCONTINUANCE/RESTORATION REQUIREMENTS

1. GENERAL

This section establishes procedures to be followed when Medi-Cal benefits are to be denied/discontinued due to applicant/beneficiary request, lack of information, and loss of contact. Situations in which the worker is required to assist the applicant/beneficiary in obtaining essential verifications and/or extending the deadline for providing the verifications are also included in this section.

2. REQUEST FOR WITHDRAWAL/DISCONTINUANCE

The following procedures will apply whenever an applicant/beneficiary or person authorized to act on behalf of the applicant/beneficiary requests withdrawal of an application for Medi-Cal or requests discontinuance of Medi-Cal benefits.

A. Written Request

The applicant/beneficiary may withdraw his/her application for Medi-Cal or request discontinuance of Medi-Cal benefits by:

- 1) Indicating the request on Form MC 215; or
- 2) Submitting a signed statement indicating the request for withdrawal/discontinuance.

When a written request is received, the worker will deny/discontinue the case and send the appropriate NOA to the client (IM-EDP Manual, Sec. 5). A copy of the written request is to be filed along with the NOA in the case folder.

B. Oral Request

When an oral request for withdrawal/discontinuance is made by the applicant/beneficiary, the worker will ask that the request be made in writing. The worker must make a narrative entry of the oral request and that written confirmation has been requested. The worker will then deny/discontinue the case and send the appropriate NOA.

It is not necessary to wait for the written request before the case is denied/discontinued. When the written request is received, it is to be filed with a copy of the NOA.

C. Timely Notice

Timely notice is not required when the beneficiary provides a clear and signed written request for discontinuance of Medi-Cal benefits. Adequate notice is required.

Timely notice is required when only an oral request is made and the worker is unable to obtain a written request from the beneficiary.

D. Disputed Requests for Withdrawal/Discontinuance

If the applicant/beneficiary fails to return a written request for withdrawal/discontinuance and later disputes the oral request, and there is no other basis for denial/discontinuance, the worker will immediately rescind the action. Otherwise, the action will be considered valid.

3. DENIAL/DISCONTINUANCE DUE TO LACK OF INFORMATION

A. Promptness Requirement

The worker makes the determination of eligibility as quickly as possible, but no later than 45 days from the date of application. The intent of the promptness requirements is to provide for the timely issuance of benefits to eligible applicants. Applications are not to be denied solely because the worker has not received all required verifications within given deadlines unless the applicant/beneficiary is not cooperating within his/her ability or limitations.

The 45-day deadline for determining eligibility may be extended for any of the following reasons:

- 1) The applicant, for good cause, has been unable to get the necessary verification(s) in time for the worker to meet promptness requirements.
 - a) Good cause in this situation includes but is not limited to:
 - (1) Physical or mental illness or incapacity of the applicant/authorized representative which prevents return of the required information.
 - (2) A level of literacy of the applicant/authorized representative which, in conjunction with other social and language barriers, prevents the applicant/authorized representative from meeting the established due date.
- 2) There has been a delay in the receipt of information necessary to determine eligibility and the delay is beyond the control of either the applicant or the worker.
- 3) The applicant's guardian or other person acting in the applicant's behalf has failed to provide the essential information requested by the worker. In this situation, the extended eligibility determination period may not exceed three months from the date of application.
- 4) The applicant demonstrated good faith effort and was granted reasonable opportunity to provide evidence of citizenship and identity.

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B. Intake Worker Responsibility

In addition to providing the applicant with a list of outstanding verifications, the intake worker is required to review the applicant's ability to obtain the required verifications and offer assistance as necessary in obtaining verifications. Refer to MPG Article 4, Section 7.2.B.2 for situations which may require worker assistance. If the outstanding verifications pertain to evidence of citizenship and identity requirement under the Deficit Reduction Act (DRA) of 2005, refer to MPG Article 4, Section 7.A.3 for required worker assistance.

The type of worker assistance required varies depending on the limitation of the applicant/beneficiary or authorized representative. In some situations, assistance in identifying the address of the verification source may be all that is needed. In others, the worker may need to obtain the applicant/beneficiary's written authorization and request the verification on behalf of the applicant.

- 1) The intake worker will give the applicant at least 10 days to provide required verifications. The worker must extend the 10-day deadline if the applicant indicates that he/she may have difficulty in providing the verifications by the given deadline. If an extended deadline is agreed to, the worker will document that fact in the case narrative.
- 2) When the deadline has passed and verifications are missing, the worker must contact the applicant. Automated Letter #716 will be sent to the applicant 10 days after the date of intake interview. The worker must TIC for return of the verifications for manual intakes. AL 716 must always be sent to the applicant to allow at least another 10 days. A copy must be filed in the case. A flyer, 14-76 HHSA, is also to be sent to applicants to encourage them to provide the requested verifications. It can be sent either with the AL 716, or five days after the AL 716 if the requested items still have not been received by that time. If the applicant has a telephone, the worker must also make two attempts on two separate days in order to contact the applicant to discuss the status of pending verifications, offer additional assistance, as needed, and establish an extended deadline. If the worker reaches an answering machine, he/she is to leave a message asking the applicant to call. Each attempted contact must be narrated. **Note:** To assure confidentiality, the worker is not to identify themselves as a Medi-Cal worker or state that they are calling about Medi-Cal. They should state that they are calling on behalf of the applicant's health care coverage.
- 3) If, at the end of the second deadline, there is no contact from the applicant and no apparent reason of a need for a longer period in which to obtain the verifications, the worker will deny the application for failure to provide essential information.

The worker will need to determine which member of the MFBU lacks the required information AND determine whether the denial action applies: (1) solely to that person, or (2) to that person AND those for whom he/she is responsible, or (3) to the entire MFBU.

The worker will need to verify whether the remaining MFBU members are still

linked to the program. If not, then they will be denied as Medi-Cal linkage does not exist.

- 4) If the applicant contacts the worker within 10 days of the denial notice date and requests additional time to provide verifications, the worker will evaluate the applicant's reasons for requiring additional time. The worker will allow additional time if it appears that the applicant is making a good faith effort to obtain the verifications, and/or the delay is beyond the applicant's control. The contact with the applicant and the worker decision must be documented in the case file. If an extended period is allowed and verifications are not provided by the deadline, a second denial NOA is to be sent. However, no additional denial action is to be recorded on computer documents. If the verifications are provided, and eligibility exists, the original denial is to be rescinded.
- 5) If there is no contact from the applicant, but verifications are received within 10 days of the denial notice date, the worker must consider the verifications timely and rescind the denial, if otherwise eligible. If some verifications are still missing, the worker must document the case file and send a note to the applicant stating that the original denial stands. A copy of the note is to be filed in the case. If all verifications are provided but ineligibility exists for a different reason, a second denial NOA must be sent. No additional denial action is to be recorded on Line E of the 278 LM computer document.
- 6) If the applicant contacts the worker, or the worker receives the missing verifications, more than 10 days after the denial notice date, the denial will stand, and the applicant must be advised to reapply. However, the ES may approve rescission of the denial under extenuating circumstances. Extenuating circumstances could include an applicant who has been hospitalized, or had a similar family emergency, and contacts the worker within a day or two after the emergency is over.

The applicant must be advised of the decision either orally or in writing. The worker must document the verbal contact in the case narrative, or file a copy of any written contact in the case file, on top of the denial NOA. No additional denial action is to be recorded on Line E of the 278 LM computer document.

C. Granted Worker Responsibility

A second phone contact attempt is required before Medi-Cal benefits may be discontinued for a failure to provide reason. (See MPG 4-13-A for failure to provide grid). The phone contact attempts are to be made as follows:

- 1) Make the first phone contact attempt on the day that a written request for the missing item(s) is mailed.
- 2) Make the second contact on the fifth business day after the written request for the missing item(s) was mailed or when partial items are received from the first request.
- 3) If only partial items are provided after two attempted phone contacts have been made, a courtesy phone contact is suggested to clarify what is needed.

The worker must document all phone contacts, and/or attempted phone contacts, in

the case narrative. In addition to the phone contact, workers are encouraged to mail out the Reminder Flyer 14-76 HHSA (DISC) to promote the importance of health coverage and to encourage beneficiaries to return the forms.

Workers are precluded from requesting certain information from a Medi-Cal beneficiary to complete an eligibility review. Workers are not to request information which:

- has been previously provided within 12 months from the date the eligibility determination was made; and
- is not subject to change;
- is available for verification by the worker (for example, in an other PA case file); or
- is not absolutely necessary.

The granted worker will follow the same general procedures as the intake worker (see 3B above) in evaluating the beneficiary's need for assistance in obtaining verifications needed for redetermination or upon change of eligibility or share of cost factors. Certification for Medi-Cal shall not be delayed or discontinued pending verifications from a person who is currently eligible unless the beneficiary refuses to cooperate.

4. VERIFICATIONS UNAVAILABLE

A. When to Consider Verification Unavailable

Verification of income or property are to be considered unavailable under any of the following, or similar, conditions:

- 1) Pursuit of the verification would put the applicant/beneficiary in some bodily danger or would result in loss of employment.
- 2) Records were destroyed by fire, flood, etc.
- 3) The source of verification is uncooperative.

B. Worker Responsibility

The worker must evaluate each situation where the applicant states that a verification is unavailable. A reasonable attempt by either the applicant or the worker must have been made to obtain the verification. The attempt may be by telephone or in writing to the source of the verification.

The requirement to contact the verification source may be waived, with ES approval, if the applicant states that such contacts would jeopardize employment or put the applicant/beneficiary in danger of physical harm. In this situation, the applicant/beneficiary must provide a sworn statement describing the basis of his/her contention that pursuit of the verification would jeopardize them physically, or lead to loss of employment.

All actions taken by the applicant/beneficiary and/or the worker to obtain verification must be documented in the case narrative.

C. Case Documentation

When the worker determines that a verification is unavailable, a sworn statement from the applicant/beneficiary dated and signed under the penalty of perjury must be completed. The sworn statement must include a description and value of property, or the gross amount, deductions, and date(s) of receipt of income.

5. LOSS OF CONTACT

An application for Medi-Cal is to be denied or an active Medi-Cal case discontinued if, after reasonable attempts to contact the applicant/beneficiary, the worker determines that there is loss of contact.

A. Reasonable Attempts

Upon receipt of returned mail, or other indication that the applicant/beneficiary has moved, and there has been no change of address reported, the worker must make reasonable attempts to contact the applicant beneficiary.

1) Client Has Telephone

If the client has a telephone, the worker must attempt to call the client. If there is no answer, the telephone has been disconnected, or the person answering the telephone confirms that the client has moved and left no forwarding address, the worker will deny/discontinue the case. The worker must document the attempt to contact the client in the case narrative.

If telephone contact is made and the worker is able to confirm that the client has not moved, the contact will be documented in the case narrative. No further action is necessary.

2) Client Does Not Have Telephone

If the client does not have a telephone, the worker must send a letter to the client requesting that the client contact the worker within 10 days to confirm his/her whereabouts. If the client responds to the letter and confirms his/her whereabouts, the worker will document the contact in the case narrative. No further action is to be taken.

If the client does not respond to the letter within 10 days, the worker will deny/discontinue the case. The worker must document in the case narrative the attempt to contact the client by mail and the client's failure to respond.

B. Timely Notice

Timely notice is not required for the discontinuance of Medi-Cal benefits due to loss of contact where mail sent by DSS to the beneficiary has been returned indicating no forwarding address. Adequate notice is required in these situations.

C. Client Contacts Worker After Denial/Discontinuance

1) Denial for Loss of Contact

If the applicant contacts the worker within 10 calendar days from the date of the denial NOA and confirms his/her whereabouts, the worker will rescind the denial.

If the applicant contacts the worker more than 10 days from the denial notice date, the denial will stand and the worker will advise the applicant to reapply. However, the ES may approve rescission of the denial under extenuating circumstances.

2) Discontinue for Loss of Contact

If the beneficiary contacts the worker prior to the date of discontinuance and confirms his/her whereabouts, the worker will rescind the discontinuance.

If the beneficiary contacts the worker after the date of discontinuance, the discontinuance will stand and the beneficiary will be advised to reapply. The ES may approve rescission of the discontinuance if extenuating circumstances exist.

6. RESCISSION OF MEDI-CAL DENIAL/DISCONTINUANCE

The worker must rescind the denial/discontinuance of the Medi-Cal case when any of the following conditions apply:

- A. A state hearing decision orders rescission of the denial/discontinuance; or
- B. The worker receives an Out of Hearing Resolution from Appeals instructing the worker to rescind the denial/discontinuance.
- C. The worker/ES determines that the denial/discontinuance was in error.

7. RESTORATION OF FULL-SCOPE MEDI-CAL

The following procedures apply whenever an applicant/beneficiary provides acceptable evidence of citizenship/identity after "limited scope" benefits are granted.

A. Restoring Full-Scope

Applicants or beneficiaries who receive "limited scope" Medi-Cal for failure to provide evidence of citizenship/identity will have their full scope eligibility restored back to the month that limited scope eligibility began, including any retroactive period, if both of the following conditions are met:

- Had good cause for not providing the required documents at application or redetermination; **AND**
- Provided the required evidence within one year of their application or redetermination date.

If the required evidence is provided more than one year from the application or

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redetermination date, full-scope eligibility will be effective the first of the month in which the required documentation is received.

B. Determining Good Cause

Good cause exists when the applicant or beneficiary is unable to provide acceptable evidence of citizenship and/or identity for reasons beyond his/her control or knowledge.

Examples of good cause in these cases include but are not limited to:

- A prior belief that the documents did not exist or were unattainable.
- Mental or physical impairment that was an impediment to obtaining the documents
- Securing the documents could result in physical danger or familial discord.

Refer to MPG 7.2.06 regarding special consideration for pregnant women.

C. Medi-Cal Reimbursement

1) Previously Paid Expenses

Applicants or current beneficiaries who paid for medical or dental care while obtaining their citizenship and identity documents may be reimbursed by Medi-Cal for these expenses. In these cases, the applicant or current beneficiary shall be referred to the California Department of Health Services Beneficiary Services at (916) 403-2007 for more information.

2) Outstanding Expenses

For medical and dental bills that have not yet been paid and if warranted under the good cause provision as specified above in MPG 4-13-7B, an Eligibility Letter of Authorization (MC 180) will be issued upon request to facilitate the payment of services rendered by providers more than one year after the month of service. Refer to MPG 14-3-9 for procedures on completion of MC 180.

FAILURE TO PROVIDE TIMEFRAMES

REDETERMINATION DUE		
Step 1: Day One	<ol style="list-style-type: none"> 1. Mail MC 210 RV and packet with cover letter 2. TIC calendar for 20 days 	
Step 2: After 20 Days	If beneficiary provides partial verification, worker must perform an <i>ex parte</i> review to attempt to locate needed verification in Other PA cases or in county accessible systems. If unsuccessful: <ol style="list-style-type: none"> 1. Attempt 1st phone contact (P/C) 2. Mail 1st AL 971 3. TIC calendar for 20 days 4. Attempt 2nd P/C on the 5th business day after the 1st AL 971 was mailed 	If beneficiary fails to provide requested verification, worker must perform an <i>ex parte</i> review to attempt to locate needed verification in Other PA cases or in county accessible systems. If unsuccessful: <ol style="list-style-type: none"> 1. Discontinue case with 10-day notice 2. Mail Discontinuance NOA 3. Attempt 1st phone contact (P/C) 4. Attempt 2nd P/C on the 5th business day after the discontinuance NOA was mailed
Step 3: After 2 nd 20 Days	If beneficiary provides partial verification: <ol style="list-style-type: none"> 1. Mail a 2nd AL 971 2. TIC calendar for 10 days 3. Courtesy P/C if time allows 	
Step 4: After 10 Days	If beneficiary fails to provide requested verifications: <ol style="list-style-type: none"> 1. Discontinue case with 10-day notice 	
BENEFICIARY REPORTS CHANGE THAT AFFECTS ELIGIBILITY		
Step 1: Day One	If beneficiary provides partial verification, worker must perform an <i>ex parte</i> review to attempt to locate needed verification in Other PA cases or in county accessible systems. If unsuccessful: <ol style="list-style-type: none"> 1. Attempt 1st P/C 2. Mail 1st AL 971 3. TIC calendar for 20 days 4. Attempt 2nd P/C on the 20^h day after the AL 971 was mailed <p><i>*Note:</i> Workers must always attempt to locate needed verification/information by means of an <i>ex parte</i> review prior to requesting it from the beneficiary.</p>	
Step 2: After 20 Days	If beneficiary provides partial verification: <ol style="list-style-type: none"> 1. Mail a 2nd AL 971 2. TIC calendar for 10 days 3. After 5 business days, attempt courtesy P/C or 2nd P/C if not made in Step 1 above 	If beneficiary fails to provide requested verifications: <ol style="list-style-type: none"> 1. Discontinue case with 10-day notice 2. Mail Discontinuance NOA 3. Courtesy P/C
Step 3: After 10 Days	If beneficiary fails to provide requested verifications: <ol style="list-style-type: none"> 1. Discontinue case with 10-day notice 	
WHEREABOUTS UNKNOWN – Mail Returns Whereabouts Unknown		
Post office returns the MC 210 RV or 1 st AL 971 with no forwarding address and undeliverable	<ol style="list-style-type: none"> 1. Attempt P/C. If contact is unsuccessful, then step 2 2. Discontinue case. No 10-day notice required 	
Post office returns the MC 210 RV or 1 st AL 971 with a forwarding address	<ol style="list-style-type: none"> 1. Re-mail AL 971 2. Follow the above procedures according to the appropriate scenario 	